

14232

CERTIFICATE OF DEATH

14224

Reg. Dist. No.

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH o. COUNTY TALBOT MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md b. COUNTY CAROLINE | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Denton - RURAL 05X-2 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Easter Memorial Hosp. | | | | d. STREET ADDRESS NEAR BUREAU | | | |
| e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Mattie Middle ELLEN Last Andrew | | | | 4. DATE OF DEATH Month 12 - Day 8 Year 1958 | | | |
| 5. SEX Fe | | 6. COLOR OR RACE white | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 2-11-1880 | |
| 9. AGE (In years lost birthday) 78 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W. | | | | 10b. KIND OF BUSINESS OR INDUSTRY HOME | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME Willis Poole | | | | 14. MOTHER'S MAIDEN NAME Sarah Le Compté | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. UNKNOWN | | 17. INFORMANT Address MRS. JACOB ZIERL, DENTON, MARYLAND, RFD. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure | | | | | | | |
| 420.1 DUE TO Old myocardial Infarct | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary occlusion. | | | | | | | |
| (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Good Rheumatic pericarditis | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 3:05 PM from the causes and on the date stated above. | | | | | | | |
| ADDRESS (Street, city or town, state) 2195 Washington St. N. 10th St. DATE SIGNED Dec 58 | | | | | | | |
| ACTUAL SIGNATURE E. C. H. Schmidt M.D. Easton 16, Maryland | | | | | | | |
| PHYSICIAN'S NAME (Type) E. C. H. Schmidt | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF DEC. 11, 1958 | | 22c. NAME OF CEMETERY OR CREMATORY CONCORD CEMETERY | | 22d. LOCATION (City, town, or county) (State) NEAR FEDERALSBURG MD | |
| 23. FUNERAL DIRECTOR'S SIGNATURE J. J. Hampton Son ADDRESS Federalsburg Md. | | | | 24a. REC'D BY REGISTRAR DATE DEC 15 58 | | 24b. REGISTRAR'S SIGNATURE William S. Thoms | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | |
|--|--|---|--|
| 1. NAME OF DECEASED JAMES H. HARRIS | | 2. SEX Male | |
| 3. AGE 65 | | 4. RACE White | |
| 5. DATE OF DEATH Dec 10 1914 | | 6. PLACE OF DEATH Home | |
| 7. TIME OF DEATH 10:30 AM | | 8. CAUSE OF DEATH Heart Disease | |
| 9. DISEASE OR INJURY Coronary Artery Disease | | 10. PLACE OF BIRTH Maryland | |
| 11. DATE OF BIRTH Nov 15 1849 | | 12. PLACE OF DEATH Home | |
| 13. NAME OF PHYSICIAN Dr. J. H. Harris | | 14. NAME OF FUNERAL HOME None | |
| 15. NAME OF BURIAL PLACE None | | 16. NAME OF CEMETERY None | |
| 17. NAME OF MINISTER None | | 18. NAME OF CHURCH None | |
| 19. NAME OF CLERGYMAN None | | 20. NAME OF DECEASED'S WIFE None | |
| 21. NAME OF DECEASED'S CHILDREN None | | 22. NAME OF DECEASED'S PARENTS None | |
| 23. NAME OF DECEASED'S SIBLINGS None | | 24. NAME OF DECEASED'S BROTHERS None | |
| 25. NAME OF DECEASED'S SISTERS None | | 26. NAME OF DECEASED'S UNCLE None | |
| 27. NAME OF DECEASED'S AUNT None | | 28. NAME OF DECEASED'S GRANDFATHER None | |
| 29. NAME OF DECEASED'S GRANDMOTHER None | | 30. NAME OF DECEASED'S GREAT-GRANDFATHER None | |
| 31. NAME OF DECEASED'S GREAT-GRANDMOTHER None | | 32. NAME OF DECEASED'S GREAT-GRANDFATHER None | |
| 33. NAME OF DECEASED'S GREAT-GRANDMOTHER None | | 34. NAME OF DECEASED'S GREAT-GRANDFATHER None | |
| 35. NAME OF DECEASED'S GREAT-GRANDMOTHER None | | 36. NAME OF DECEASED'S GREAT-GRANDFATHER None | |
| 37. NAME OF DECEASED'S GREAT-GRANDMOTHER None | | 38. NAME OF DECEASED'S GREAT-GRANDFATHER None | |
| 39. NAME OF DECEASED'S GREAT-GRANDMOTHER None | | 40. NAME OF DECEASED'S GREAT-GRANDFATHER None | |
| 41. NAME OF DECEASED'S GREAT-GRANDMOTHER None | | 42. NAME OF DECEASED'S GREAT-GRANDFATHER None | |
| 43. NAME OF DECEASED'S GREAT-GRANDMOTHER None | | 44. NAME OF DECEASED'S GREAT-GRANDFATHER None | |
| 45. NAME OF DECEASED'S GREAT-GRANDMOTHER None | | 46. NAME OF DECEASED'S GREAT-GRANDFATHER None | |
| 47. NAME OF DECEASED'S GREAT-GRANDMOTHER None | | 48. NAME OF DECEASED'S GREAT-GRANDFATHER None | |
| 49. NAME OF DECEASED'S GREAT-GRANDMOTHER None | | 50. NAME OF DECEASED'S GREAT-GRANDFATHER None | |
| 51. NAME OF DECEASED'S GREAT-GRANDMOTHER None | | 52. NAME OF DECEASED'S GREAT-GRANDFATHER None | |
| 53. NAME OF DECEASED'S GREAT-GRANDMOTHER None | | 54. NAME OF DECEASED'S GREAT-GRANDFATHER None | |
| 55. NAME OF DECEASED'S GREAT-GRANDMOTHER None | | 56. NAME OF DECEASED'S GREAT-GRANDFATHER None | |
| 57. NAME OF DECEASED'S GREAT-GRANDMOTHER None | | 58. NAME OF DECEASED'S GREAT-GRANDFATHER None | |
| 59. NAME OF DECEASED'S GREAT-GRANDMOTHER None | | 60. NAME OF DECEASED'S GREAT-GRANDFATHER None | |
| 61. NAME OF DECEASED'S GREAT-GRANDMOTHER None | | 62. NAME OF DECEASED'S GREAT-GRANDFATHER None | |
| 63. NAME OF DECEASED'S GREAT-GRANDMOTHER None | | 64. NAME OF DECEASED'S GREAT-GRANDFATHER None | |
| 65. NAME OF DECEASED'S GREAT-GRANDMOTHER None | | 66. NAME OF DECEASED'S GREAT-GRANDFATHER None | |
| 67. NAME OF DECEASED'S GREAT-GRANDMOTHER None | | 68. NAME OF DECEASED'S GREAT-GRANDFATHER None | |
| 69. NAME OF DECEASED'S GREAT-GRANDMOTHER None | | 70. NAME OF DECEASED'S GREAT-GRANDFATHER None | |
| 71. NAME OF DECEASED'S GREAT-GRANDMOTHER None | | 72. NAME OF DECEASED'S GREAT-GRANDFATHER None | |
| 73. NAME OF DECEASED'S GREAT-GRANDMOTHER None | | 74. NAME OF DECEASED'S GREAT-GRANDFATHER None | |
| 75. NAME OF DECEASED'S GREAT-GRANDMOTHER None | | 76. NAME OF DECEASED'S GREAT-GRANDFATHER None | |
| 77. NAME OF DECEASED'S GREAT-GRANDMOTHER None | | 78. NAME OF DECEASED'S GREAT-GRANDFATHER None | |
| 79. NAME OF DECEASED'S GREAT-GRANDMOTHER None | | 80. NAME OF DECEASED'S GREAT-GRANDFATHER None | |
| 81. NAME OF DECEASED'S GREAT-GRANDMOTHER None | | 82. NAME OF DECEASED'S GREAT-GRANDFATHER None | |
| 83. NAME OF DECEASED'S GREAT-GRANDMOTHER None | | 84. NAME OF DECEASED'S GREAT-GRANDFATHER None | |
| 85. NAME OF DECEASED'S GREAT-GRANDMOTHER None | | 86. NAME OF DECEASED'S GREAT-GRANDFATHER None | |
| 87. NAME OF DECEASED'S GREAT-GRANDMOTHER None | | 88. NAME OF DECEASED'S GREAT-GRANDFATHER None | |
| 89. NAME OF DECEASED'S GREAT-GRANDMOTHER None | | 90. NAME OF DECEASED'S GREAT-GRANDFATHER None | |
| 91. NAME OF DECEASED'S GREAT-GRANDMOTHER None | | 92. NAME OF DECEASED'S GREAT-GRANDFATHER None | |
| 93. NAME OF DECEASED'S GREAT-GRANDMOTHER None | | 94. NAME OF DECEASED'S GREAT-GRANDFATHER None | |
| 95. NAME OF DECEASED'S GREAT-GRANDMOTHER None | | 96. NAME OF DECEASED'S GREAT-GRANDFATHER None | |
| 97. NAME OF DECEASED'S GREAT-GRANDMOTHER None | | 98. NAME OF DECEASED'S GREAT-GRANDFATHER None | |
| 99. NAME OF DECEASED'S GREAT-GRANDMOTHER None | | 100. NAME OF DECEASED'S GREAT-GRANDFATHER None | |

1. This is to certify that the above is a true and correct copy of the original as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the 10th day of December, 1914.

2. I hereby certify that the above is a true and correct copy of the original as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the 10th day of December, 1914.

3. I hereby certify that the above is a true and correct copy of the original as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the 10th day of December, 1914.

4. I hereby certify that the above is a true and correct copy of the original as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the 10th day of December, 1914.

5. I hereby certify that the above is a true and correct copy of the original as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the 10th day of December, 1914.

6. I hereby certify that the above is a true and correct copy of the original as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the 10th day of December, 1914.

7. I hereby certify that the above is a true and correct copy of the original as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the 10th day of December, 1914.

8. I hereby certify that the above is a true and correct copy of the original as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the 10th day of December, 1914.

9. I hereby certify that the above is a true and correct copy of the original as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the 10th day of December, 1914.

10. I hereby certify that the above is a true and correct copy of the original as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the 10th day of December, 1914.

14233

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|---------------------------|--|---------------------------------------|---|--|--|--|
| 1. PLACE OF DEATH o. COUNTY <u>Talbot</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>40 Easton</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | d. STREET ADDRESS <u>1 S Washington</u> | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Silas</u> Last <u>Barnes</u> | | | | 4. DATE OF DEATH Month <u>Dec.</u> Day <u>26</u> Year <u>1958</u> | | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Nov. 11, 1899</u> | 9. AGE (In years last birthday) <u>59</u> yrs. | IF UNDER 1 YEAR Months <u>1</u> Days <u>5</u> | IF UNDER 24 HRS. Hours <u></u> Min. <u></u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Banker</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Banking</u> | | 11. BIRTHPLACE (State or foreign country) <u>Talbot County, Md</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>J. Harry Barnes</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Alice Sullivan</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>21203-5999</u> | | 17. INFORMANT <u>Ernest C. Barnes</u> | | Address <u>Easton, Md</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Cerebral thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral atherosclerosis</u> (c) <u></u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>addition</u> (c) <u>(?)</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Essential hypertension</u> | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u></u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <u>Jan</u> 19 <u>52</u> , to <u>26 Dec</u> 19 <u>58</u> , that I last saw the deceased alive on <u>23 Dec 58</u> , 19 <u>58</u> , and that death occurred at <u>8:54</u> M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Arthur S. Harrison</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>Easton, Maryland</u> DATE SIGNED <u>27 Dec 58</u> | | | |
| PHYSICIAN'S NAME (Type) <u>THURSTON HARRISON</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Dec. 29, 58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Grange Hill</u> | | 22d. LOCATION (City, town, or county) (State) <u>Easton Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Harrison</u> ADDRESS <u>Easton Md</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>DEC 30 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harrison</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14252

CERTIFICATE OF DEATH

14226

Reg. Dist. No.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE MARYLAND b. COUNTY TALBOT | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SHERWOOD | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SHERWOOD | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | d. STREET ADDRESS | | | |
| 3. NAME OF DECEASED (Type or print) MARY C. BENHOFF | | | | 4. DATE OF DEATH DECEMBER 25, 1958 | | | |
| 5. SEX FEMALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH AUG 17, 1875 | |
| 9. AGE (In years last birthday) 83 yrs. | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY — | | 11. BIRTHPLACE (State or foreign country) GERMANY | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME WILHELM FREDRICK KOCH | | | | 14. MOTHER'S MAIDEN NAME CATHERINE SCHREITZ | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. — | | 17. INFORMANT EARLE C. BENHOFF Address 116 S. MAPLE AVE SPRINGFIELD N.J. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) atherosclerotic cardiovascular DUE TO (c) — | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 hrs. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypertension, Essential vascular, chronic cardiac failure | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 8-3-1957 to 12-25-1958 , that I last saw the deceased alive on 12-25-1958 , and that death occurred at 8:45 P.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Guy M. Rogers M.D. | | | | DATE SIGNED 12-26-58 | | | |
| PHYSICIAN'S NAME (Type) Guy M. Rogers | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF DEC. 29, 1958 | | 22c. NAME OF CEMETERY OR CREMATORY TRINITY CEMETERY | | 22d. LOCATION (City, town, or county) (State) BALTIMORE, M.D. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Hamilton Harrison ADDRESS St. Michaels | | | | 24a. REC'D BY REGISTRAR DEC 30 '58 | | 24b. REGISTRAR'S SIGNATURE Charles E. Phaul | |

14234 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|---------------------------|--|---|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> | | | | c. LENGTH OF STAY IN 1b <u>8 yrs</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u> | | | | d. STREET ADDRESS <u>NEAR FINCHVILLE</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Reuben</u> Middle <u>Henry</u> Last <u>Bolden</u> | | | | 4. DATE OF DEATH Month <u>December</u> Day <u>15</u> Year <u>1958</u> | | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>C</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>December 14, 1898</u> | | 9. AGE (In years last birthday) <u>68</u> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DAY LABORER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>George Bolden</u> | | | | 14. MOTHER'S MAIDEN NAME <u>IRMA DICKERSON</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>218-20-4009</u> | | 17. INFORMANT Address <u>NETTIE M. BOLDEN, FEDERALSBURG, MD. RFD</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Intracranial Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>7:55 P.</u> M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>E. C. H. Schmidt</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>219 S. Washington St. Federalburg, Md.</u> DATE SIGNED <u>16 Dec 58</u> | | | |
| PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u> | | | | ADDRESS <u>Easton, Md.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>DEC. 18, 1958</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>FEDERAL HILL CEMETERY</u> | | 22d. LOCATION (City, town, or county) (State) <u>FEDERALSBURG, MD.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Trappone, Inc. Federalburg, Md.</u> ADDRESS | | | | 24a. REC'D BY REGISTRAR <u>DEC 22 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100

14235 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|--|--|---|---|
| 1. PLACE OF DEATH o. COUNTY TALBOT MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Talbot | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON Talbot | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Sarah Middle J Last Boyle | | | | 4. DATE OF DEATH Month 12 - Day 10 Year 1958 | | | |
| 5. SEX Fe | | 6. COLOR OR RACE W | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH June 8 1873 | |
| 9. AGE (In years last birthday) 85 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gen | | 11. BIRTHPLACE (State or foreign country) Canada | | 12. CITIZEN OF WHAT COUNTRY? Canada | |
| 13. FATHER'S NAME Robert Boyle | | | | 14. MOTHER'S MAIDEN NAME Mary Jane Richardson | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Aneurysm 443x DUE TO H. E. V. D. + Arterio Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Congestive heart failure | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Dec. 12 , 19 58 , to Dec. 10 , 19 58 , that I last saw the deceased alive on Dec. 10 , 19 58 , and that death occurred at 7:45 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Frederick, Md. DATE SIGNED Early, Jr. | | | | | | | |
| ACTUAL SIGNATURE James H. Kearney M.D. | | | | | | | |
| PHYSICIAN'S NAME (Type) Early, Jr. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Dec. 13, 1958 | | 22c. NAME OF CEMETERY OR CREMATORY Winthrop | | 22d. LOCATION (City, town, or county) (State) East, Boston Mass. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE James H. Kearney ADDRESS Talbot, Maryland | | | | 24a. REC'D BY REGISTRAR DEC 12 '58 | | 24b. REGISTRAR'S SIGNATURE Arthur L. Evans | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH o. COUNTY <i>Talbot</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Talbot</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i> | | c. LENGTH OF STAY IN 1b <i>19 days</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i> | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>ST. Michaels</i> | |
| 3. NAME OF DECEASED (Type or print) First <i>Grace</i> Middle <i>Cranner</i> Last <i>Cranner</i> | | 4. DATE OF DEATH Month <i>December</i> Day <i>27</i> Year <i>1958</i> | |
| 5. SEX <i>F</i> | 6. COLOR OR RACE <i>W</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>October 28, 1884</i> |
| 9. AGE (In years last birthday) <i>74</i> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>—</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>England</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 13. FATHER'S NAME <i>Thomas Baker</i> | | 14. MOTHER'S MAIDEN NAME <i>Charlotte Cook</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i> (If yes, give war or dates of service) <i>—</i> | | 16. SOCIAL SECURITY NO. <i>—</i> | |
| 17. INFORMANT <i>Wm. CRANNER</i> | | Address <i>ST. MICHAELS, MD</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vascular Accident</i> DUE TO <i>443X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary Heart Fail.</i> DUE TO <i>4 years</i> (c) <i>Hypertensive Cardiovascular Dis.</i> <i>10 years</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>4 years</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>—</i> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <i>29 Nov.</i> 1958, to <i>27 Dec.</i> 1958, that I last saw the deceased alive on <i>22 Dec.</i> 1958, and that death occurred at <i>8 P.</i> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>K. Anne Wholly</i> | | ADDRESS (Street, city or town, state) <i>Box 487, St. Michaels, Md.</i> | |
| DATE SIGNED <i>12-23-58</i> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 22b. DATE THEREOF <i>12/24/58</i> | |
| 22c. NAME OF CEMETERY OR CREMATORY <i>St. Michaels</i> | | 22d. LOCATION (City, town, or county) (State) <i>St. Michaels, Md.</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>H. Hambleton</i> | | ADDRESS <i>St. Michaels, Md.</i> | |
| 24a. REC'D BY REGISTRAR <i>—</i> | | 24b. REGISTRAR'S SIGNATURE <i>William S. Travis</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | |
|--|--|--|--|
| PLACE OF DEATH (City, town, village, or county) | | MARRIAGE (Date and place of marriage) | |
| DATE OF DEATH (Month, day, and year) | | DATE OF BIRTH (Month, day, and year) | |
| NAME OF DECEASED (Full name, including maiden name, if applicable) | | NAME OF DECEASED (Full name, including maiden name, if applicable) | |
| SEX (Male or Female) | | SEX (Male or Female) | |
| RACE (White, Negro, or other) | | RACE (White, Negro, or other) | |
| EDUCATION (School, college, or other) | | EDUCATION (School, college, or other) | |
| OCCUPATION (Profession, trade, or other) | | OCCUPATION (Profession, trade, or other) | |
| CAUSE OF DEATH (Immediate cause, underlying cause, and contributing causes) | | CAUSE OF DEATH (Immediate cause, underlying cause, and contributing causes) | |
| MANNER OF DEATH (Natural, accidental, or suicidal) | | MANNER OF DEATH (Natural, accidental, or suicidal) | |
| SIGNATURE OF DECEASED (If known) | | SIGNATURE OF DECEASED (If known) | |
| SIGNATURE OF WITNESSES (Two or more persons) | | SIGNATURE OF WITNESSES (Two or more persons) | |
| SIGNATURE OF PHYSICIAN (If known) | | SIGNATURE OF PHYSICIAN (If known) | |
| SIGNATURE OF CLERK (If known) | | SIGNATURE OF CLERK (If known) | |
| DATE OF FILING (Month, day, and year) | | DATE OF FILING (Month, day, and year) | |

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE CLERK OF THE BALTIMORE CITY CLERK'S OFFICE, BALTIMORE, MARYLAND, AND IN THE OFFICE OF THE CLERK OF THE BALTIMORE COUNTY CLERK'S OFFICE, BALTIMORE, MARYLAND.

14237 CERTIFICATE OF DEATH

14230

Reg. Dist. No.

| | | | |
|--|-----------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Michaels</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u> | | d. STREET ADDRESS <u>1</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Walter D.</u> Middle <u>Davis</u> Last <u>Davis</u> | | 4. DATE OF DEATH Month <u>December</u> Day <u>28</u> Year <u>1958</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>November 2 1892</u> |
| 9. AGE (In years last birthday) <u>66</u> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>-</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Canada</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | |
| 13. FATHER'S NAME <u>Benjamin Davis</u> | | 14. MOTHER'S MAIDEN NAME <u>Victoria E. Misbet</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>Eva Dudman, St. Michaels and</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Arteriosclerosis</u> DUE TO (c) <u>10 yrs.</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Sudden internal bleeding etc.</u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>17 Dec.</u> , 19 <u>58</u> , to <u>28 Dec.</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>28 Dec.</u> , 19 <u>58</u> , and that death occurred at <u>2:50 A.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>K. Russell Roth</u> M.D. | | ADDRESS (Street, city or town, state) <u>Box 487, St. Michaels, Md.</u> DATE SIGNED <u>12-29-58</u> | |
| PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>12-30-58</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Christ Church Cemetery St. Michaels</u> | 22d. LOCATION (City, town, or county) (State) <u>Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>W. S. Amberson Harrison, St. Michaels</u> | | ADDRESS <u>St. Michaels</u> | |
| 24a. REC'D BY REGISTRAR <u>DEC 31 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MANLYND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1964

Age at Death

| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED | | 2. SEX | |
| 3. DATE OF BIRTH | | 4. PLACE OF BIRTH | |
| 5. OCCUPATION | | 6. CAUSE OF DEATH | |
| 7. PLACE OF DEATH | | 8. DATE OF DEATH | |
| 9. TIME OF DEATH | | 10. SIGNATURE OF DECEASED | |
| 11. SIGNATURE OF WITNESSES | | 12. SIGNATURE OF PHYSICIAN | |
| 13. SIGNATURE OF REGISTRAR | | 14. SIGNATURE OF CLERK | |
| 15. SIGNATURE OF JUDGE | | 16. SIGNATURE OF SHERIFF | |
| 17. SIGNATURE OF DISTRICT ATTORNEY | | 18. SIGNATURE OF COUNTY CLERK | |
| 19. SIGNATURE OF STATE CLERK | | 20. SIGNATURE OF SECRETARY OF HEALTH | |
| 21. SIGNATURE OF ASSISTANT SECRETARY OF HEALTH | | 22. SIGNATURE OF CHIEF OF BUREAU OF VITAL STATISTICS | |
| 23. SIGNATURE OF CHIEF OF BUREAU OF PUBLIC HEALTH | | 24. SIGNATURE OF CHIEF OF BUREAU OF LABOR | |
| 25. SIGNATURE OF CHIEF OF BUREAU OF EDUCATION | | 26. SIGNATURE OF CHIEF OF BUREAU OF AGRICULTURE | |
| 27. SIGNATURE OF CHIEF OF BUREAU OF COMMERCE | | 28. SIGNATURE OF CHIEF OF BUREAU OF TRANSPORTATION | |
| 29. SIGNATURE OF CHIEF OF BUREAU OF MINES | | 30. SIGNATURE OF CHIEF OF BUREAU OF FOREST SERVICE | |
| 31. SIGNATURE OF CHIEF OF BUREAU OF NATIONAL PARKS | | 32. SIGNATURE OF CHIEF OF BUREAU OF INDIAN AFFAIRS | |
| 33. SIGNATURE OF CHIEF OF BUREAU OF LAND MANAGEMENT | | 34. SIGNATURE OF CHIEF OF BUREAU OF GEOLOGICAL SURVEY | |
| 35. SIGNATURE OF CHIEF OF BUREAU OF MINERAL INVESTIGATION | | 36. SIGNATURE OF CHIEF OF BUREAU OF METEOROLOGICAL SERVICE | |
| 37. SIGNATURE OF CHIEF OF BUREAU OF AERONAUTICS | | 38. SIGNATURE OF CHIEF OF BUREAU OF NAVY | |
| 39. SIGNATURE OF CHIEF OF BUREAU OF ARMY | | 40. SIGNATURE OF CHIEF OF BUREAU OF AIR FORCE | |
| 41. SIGNATURE OF CHIEF OF BUREAU OF MARINE CORPS | | 42. SIGNATURE OF CHIEF OF BUREAU OF COAST GUARD | |
| 43. SIGNATURE OF CHIEF OF BUREAU OF LIAISON | | 44. SIGNATURE OF CHIEF OF BUREAU OF INTELLIGENCE | |
| 45. SIGNATURE OF CHIEF OF BUREAU OF SUPPLY | | 46. SIGNATURE OF CHIEF OF BUREAU OF LOGISTICS | |
| 47. SIGNATURE OF CHIEF OF BUREAU OF PERSONNEL | | 48. SIGNATURE OF CHIEF OF BUREAU OF TRAINING | |
| 49. SIGNATURE OF CHIEF OF BUREAU OF RESEARCH | | 50. SIGNATURE OF CHIEF OF BUREAU OF DEVELOPMENT | |
| 51. SIGNATURE OF CHIEF OF BUREAU OF CONSTRUCTION | | 52. SIGNATURE OF CHIEF OF BUREAU OF MAINTENANCE | |
| 53. SIGNATURE OF CHIEF OF BUREAU OF REPAIRS | | 54. SIGNATURE OF CHIEF OF BUREAU OF REPLACEMENT | |
| 55. SIGNATURE OF CHIEF OF BUREAU OF RECONSTRUCTION | | 56. SIGNATURE OF CHIEF OF BUREAU OF REPAIRS | |
| 57. SIGNATURE OF CHIEF OF BUREAU OF REPAIRS | | 58. SIGNATURE OF CHIEF OF BUREAU OF REPLACEMENT | |
| 59. SIGNATURE OF CHIEF OF BUREAU OF RECONSTRUCTION | | 60. SIGNATURE OF CHIEF OF BUREAU OF REPAIRS | |
| 61. SIGNATURE OF CHIEF OF BUREAU OF REPAIRS | | 62. SIGNATURE OF CHIEF OF BUREAU OF REPLACEMENT | |
| 63. SIGNATURE OF CHIEF OF BUREAU OF RECONSTRUCTION | | 64. SIGNATURE OF CHIEF OF BUREAU OF REPAIRS | |
| 65. SIGNATURE OF CHIEF OF BUREAU OF REPAIRS | | 66. SIGNATURE OF CHIEF OF BUREAU OF REPLACEMENT | |
| 67. SIGNATURE OF CHIEF OF BUREAU OF RECONSTRUCTION | | 68. SIGNATURE OF CHIEF OF BUREAU OF REPAIRS | |
| 69. SIGNATURE OF CHIEF OF BUREAU OF REPAIRS | | 70. SIGNATURE OF CHIEF OF BUREAU OF REPLACEMENT | |
| 71. SIGNATURE OF CHIEF OF BUREAU OF RECONSTRUCTION | | 72. SIGNATURE OF CHIEF OF BUREAU OF REPAIRS | |
| 73. SIGNATURE OF CHIEF OF BUREAU OF REPAIRS | | 74. SIGNATURE OF CHIEF OF BUREAU OF REPLACEMENT | |
| 75. SIGNATURE OF CHIEF OF BUREAU OF RECONSTRUCTION | | 76. SIGNATURE OF CHIEF OF BUREAU OF REPAIRS | |
| 77. SIGNATURE OF CHIEF OF BUREAU OF REPAIRS | | 78. SIGNATURE OF CHIEF OF BUREAU OF REPLACEMENT | |
| 79. SIGNATURE OF CHIEF OF BUREAU OF RECONSTRUCTION | | 80. SIGNATURE OF CHIEF OF BUREAU OF REPAIRS | |
| 81. SIGNATURE OF CHIEF OF BUREAU OF REPAIRS | | 82. SIGNATURE OF CHIEF OF BUREAU OF REPLACEMENT | |
| 83. SIGNATURE OF CHIEF OF BUREAU OF RECONSTRUCTION | | 84. SIGNATURE OF CHIEF OF BUREAU OF REPAIRS | |
| 85. SIGNATURE OF CHIEF OF BUREAU OF REPAIRS | | 86. SIGNATURE OF CHIEF OF BUREAU OF REPLACEMENT | |
| 87. SIGNATURE OF CHIEF OF BUREAU OF RECONSTRUCTION | | 88. SIGNATURE OF CHIEF OF BUREAU OF REPAIRS | |
| 89. SIGNATURE OF CHIEF OF BUREAU OF REPAIRS | | 90. SIGNATURE OF CHIEF OF BUREAU OF REPLACEMENT | |
| 91. SIGNATURE OF CHIEF OF BUREAU OF RECONSTRUCTION | | 92. SIGNATURE OF CHIEF OF BUREAU OF REPAIRS | |
| 93. SIGNATURE OF CHIEF OF BUREAU OF REPAIRS | | 94. SIGNATURE OF CHIEF OF BUREAU OF REPLACEMENT | |
| 95. SIGNATURE OF CHIEF OF BUREAU OF RECONSTRUCTION | | 96. SIGNATURE OF CHIEF OF BUREAU OF REPAIRS | |
| 97. SIGNATURE OF CHIEF OF BUREAU OF REPAIRS | | 98. SIGNATURE OF CHIEF OF BUREAU OF REPLACEMENT | |
| 99. SIGNATURE OF CHIEF OF BUREAU OF RECONSTRUCTION | | 100. SIGNATURE OF CHIEF OF BUREAU OF REPAIRS | |

14231

14238

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Talbot</u> | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> | | b. COUNTY <u>Talbot</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton.</u> | | c. LENGTH OF STAY IN 1b <u>9 days.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>40 Easton.</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u> | | | | d. STREET ADDRESS <u>617 Park Street</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | | First <u>Agnes</u> | | Middle <u>Fogel</u> | | Last | |
| 5. SEX <u>F</u> | | 6. COLOR OR RACE <u>C</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>November 13, 1922</u> | |
| 9. AGE (In years last birthday) <u>36</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | 9. DATE OF DEATH Month <u>December</u> Day <u>6</u> Year <u>1958</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Factory Worker</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Tomato Factory</u> | | 11. BIRTHPLACE (State or foreign country) <u>North Carolina</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Eddie Miller</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Chattie</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. <u> </u> | | 17. INFORMANT <u>John Gibson</u> | | Address <u>Easton, Md</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Tuberculosis</u> <u>002X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>Months</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>11-28</u> , 19 <u>58</u> , to <u>12-6</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>12-6</u> , 19 <u>58</u> , and that death occurred at <u>9:50 P.</u> M., from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Donald F. Bartley</u> | | M.D. <u> </u> | | ADDRESS (Street, city or town, state) <u>9 N. HANSON ST.</u> | | DATE SIGNED <u>12-13-58</u> | |
| PHYSICIAN'S NAME (Type) <u>DONALD F. BARTLEY M.D.</u> | | <u>EASTON, MD.</u> | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>12/12/58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Wilmington Cem.</u> | | 22d. LOCATION (City, town, or county) (State) <u>Wilmington N.C.</u> | |
| 23. FLUMERAL DIRECTOR'S SIGNATURE <u>James B. Pichard</u> | | | | ADDRESS <u>Easton Md</u> | | 24a. REC'D BY REGISTRAR DATE <u>DEC 22 '58</u> | |
| | | | | | | 24b. REGISTRAR'S SIGNATURE <u> </u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

1901

REG. NO. 1881

| | | | |
|-----------------------------------|--|-----------------------------------|--|
| <p>1. NAME OF DECEASED</p> | | <p>2. SEX</p> | |
| <p>3. AGE</p> | | <p>4. DATE OF BIRTH</p> | |
| <p>5. PLACE OF BIRTH</p> | | <p>6. OCCUPATION</p> | |
| <p>7. CAUSE OF DEATH</p> | | <p>8. PLACE OF DEATH</p> | |
| <p>9. TIME OF DEATH</p> | | <p>10. SIGNATURE OF DECEASED</p> | |
| <p>11. SIGNATURE OF WITNESSES</p> | | <p>12. SIGNATURE OF PHYSICIAN</p> | |
| <p>13. SIGNATURE OF CLERK</p> | | <p>14. SIGNATURE OF REGISTRAR</p> | |

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

14239

CERTIFICATE OF DEATH

14233

Reg. Dist. No.

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH o. COUNTY <u>Talbot</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> | | | | c. LENGTH OF STAY IN 1b <u>15 min</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u> | | | | d. STREET ADDRESS <u>Chester</u> <u>17X-2</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Ray</u> Middle <u>Gardner</u> Last <u>Gardner</u> | | | | 4. DATE OF DEATH Month <u>December</u> Day <u>15</u> Year <u>1958</u> | | | |
| 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>March 11, 1896</u> | |
| 9. AGE (In years last birthday) <u>62</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Caretaker</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>William Gardner</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Virginia Harris</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>218-34-7983</u> | | | |
| 17. INFORMANT <u>Mrs. Gardner</u> | | | | Address <u>Chester Mo.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Massive Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Crowning occlusion</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____ | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____ | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ | |
| 20f. (City or town) _____ (County) _____ (State) _____ | | | | 20g. (City or town) _____ (County) _____ (State) _____ | | | |
| 21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>10:36 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>E. C. H. Schmidt</u> | | | | DATE SIGNED <u>12/18/58</u> | | | |
| PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u> | | | | ADDRESS (Street, city or town, state) <u>2195 Westinghouse St. Easton 16, Maryland</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>12/18/58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Stevensville Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Stevensville Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L Lane</u> | | | | ADDRESS <u>Church Hill</u> | | 24a. REC'D BY REGISTRAR <u>Edgar L Lane</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>Edgar L Lane</u> | | | | DATE <u>DEC 18 1958</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

14253

CERTIFICATE OF DEATH

14234

Reg. Dist. No.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> | | | | c. LENGTH OF STAY IN 1b <u>Life</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Route 1 Box 155</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Richard J. Goldsborough</u> | | | | 4. DATE OF DEATH Month Day Year <u>12 15 1958</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>col</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>MARCH 14, 1877</u> | |
| 9. AGE (In years last birthday) <u>76</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GARDNER</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u> | | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>Henry Goldsborough</u> | | | | 14. MOTHER'S MAIDEN NAME <u>MARY GROSS</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WWI</u> | | | | 16. SOCIAL SECURITY NO. <u></u> | | | |
| 17. INFORMANT <u></u> Address <u></u> | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Hemorrhage</u> <u>331X</u> DUE TO <u>Cerebral Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PARKINSON'S DISEASE</u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from <u>Nov. 1, 1958</u> , to <u>Dec. 14, 1958</u> , that I last saw the deceased alive on <u>12/14/58</u> , and that death occurred at <u>8:30 A.M.</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Shepherd J. Krech Jr.</u> M.D. <u>EASTON</u> | | | | DATE SIGNED <u>12/17/58</u> | | | |
| PHYSICIAN'S NAME (Type) <u>SHEPARD KRECH JR.</u> | | | | ADDRESS (Street, city or town, state) <u>MARYLAND</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u> | | 22b. DATE THEREOF <u>12/18/58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Copperville Cem</u> | | 22d. LOCATION (City, town, or county) (State) <u>Easton Rt 1, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>James R. Darbyell, Easton, Md.</u> ADDRESS <u></u> | | | | 24a. REC'D BY REGISTRAR DATE <u>DEC 22 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | |
|--|--|--|--|
| 1. NAME OF DECEASED [Handwritten: <i>JOHN J. ROSS</i>] | | 2. SEX [Handwritten: <i>M</i>] | |
| 3. AGE [Handwritten: <i>65</i>] | | 4. DATE OF BIRTH [Handwritten: <i>1885</i>] | |
| 5. PLACE OF BIRTH [Handwritten: <i>NEW YORK</i>] | | 6. OCCUPATION [Handwritten: <i>DRUGGIST</i>] | |
| 7. MARITAL STATUS [Handwritten: <i>MARRIED</i>] | | 8. DATE OF MARRIAGE [Handwritten: <i>1910</i>] | |
| 9. NAME OF SPOUSE [Handwritten: <i>MARY J. ROSS</i>] | | 10. DATE OF DEATH [Handwritten: <i>1950</i>] | |
| 11. PLACE OF DEATH [Handwritten: <i>HOME</i>] | | 12. CAUSE OF DEATH [Handwritten: <i>HEART DISEASE</i>] | |
| 13. MEDICAL HISTORY [Handwritten: <i>None</i>] | | 14. SIGNATURE OF PHYSICIAN [Handwritten: <i>Dr. J. J. Smith</i>] | |
| 15. SIGNATURE OF DECEASED [Handwritten: <i>John J. Ross</i>] | | 16. SIGNATURE OF WITNESS [Handwritten: <i>Mary J. Ross</i>] | |
| 17. SIGNATURE OF REGISTRAR [Handwritten: <i>John J. Smith</i>] | | 18. SIGNATURE OF CLERK [Handwritten: <i>Mary J. Smith</i>] | |

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH. IT IS NOT VALID FOR ANY OTHER PURPOSE.

VS A15 (4)
15M 9/55

CERTIFICATE OF DEATH

| | | | |
|------------------------|--|---------------------|--|
| PLACE OF DEATH | | DATE OF DEATH | |
| HOSPITAL | | JAN 1 1918 | |
| NAME OF DECEASED | | AGE | |
| JOHN J. JONES | | 65 | |
| SEX | | M | |
| RACE | | W | |
| EDUCATION | | H | |
| OCCUPATION | | FARMER | |
| MARITAL STATUS | | M | |
| PREVAILING DISEASE | | HEART DISEASE | |
| CAUSE OF DEATH | | CORONARY THROMBOSIS | |
| MANNER OF DEATH | | NATURAL | |
| SIGNATURE OF PHYSICIAN | | DATE | |
| J. J. JONES | | JAN 1 1918 | |
| SIGNATURE OF REGISTRAR | | DATE | |
| J. J. JONES | | JAN 1 1918 | |
| SIGNATURE OF CLERK | | DATE | |
| J. J. JONES | | JAN 1 1918 | |

THIS CERTIFICATE IS TO BE FILED IN THE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND, AND A COPY IS TO BE SENT TO THE COUNTY CLERK OF THE COUNTY IN WHICH THE DECEASED RESIDED AT THE TIME OF DEATH.

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH o. COUNTY <i>Talbot</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Dorchester</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hurlock</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i> | | d. STREET ADDRESS <i>09x-2</i> | |
| 3. NAME OF DECEASED (Type or print) First <i>Charles</i> Middle <i>Jones</i> Last <i>Jr.</i> | | 4. DATE OF DEATH Month <i>December</i> Day <i>11</i> Year <i>1958</i> | |
| 5. SEX <i>M</i> | 6. COLOR OR RACE <i>Cal</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>August 27, 1958</i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday) yrs. <i>3</i> Months <i>14</i> Days <i></i> Hours <i></i> Min. <i></i> |
| 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA.</i> | |
| 13. FATHER'S NAME <i>Charles Jones, Sr.</i> | | 14. MOTHER'S MAIDEN NAME <i>Violece Jenkins</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> | | 16. SOCIAL SECURITY NO. <i></i> | |
| 17. INFORMANT <i>Charles Jones Sr. (father)</i> | | Address <i></i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Intestinal obstruction</i> 756.2 DUE TO <i>Adhesive Bands.</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Premature exploratory laparotomy</i> (c) <i></i> | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Congenital absence of bile ducts</i> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i> p. m. <i></i> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <i>19</i> to <i>19</i> , that I last saw the deceased alive on <i>19</i> , and that death occurred at <i>9:35 P.M.</i> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>E. C. H. Schmidt</i> | | DATE SIGNED <i>219 S. Washington St. 13 Dec 58</i> | |
| PHYSICIAN'S NAME (Type) <i>E. C. H. Schmidt</i> | | ADDRESS <i>Easton 16, Maryland</i> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <input checked="" type="checkbox"/> Burial | 22b. DATE THEREOF <i>12-13-58</i> | 22c. NAME OF CEMETERY OR CREMATORY <i>Johns Cemetery</i> | 22d. LOCATION (City, town, or county) (State) <i>Preston Md.</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles Jones</i> | | 24. REC'D BY REGISTRAR <i>Hurlock Md.</i> | |
| 24b. REGISTRAR'S SIGNATURE <i>Charles S. Kline</i> | | DATE <i>DEC 17 '58</i> | |

2080257XV4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

14242

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|---------------------------|--|---|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> | | | | c. LENGTH OF STAY IN 1b <u>2 hrs 20 min</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u> | | | | d. STREET ADDRESS <u>NONE</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Marie</u> Middle <u>P</u> Last <u>Kornrumpf</u> | | | | 4. DATE OF DEATH Month <u>December</u> Day <u>29</u> Year <u>1958</u> | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>August 16, 1899</u> | 9. AGE (In years last birthday) <u>59</u> yrs. | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | | 11. BIRTHPLACE (State or foreign country) <u>New York</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>John R. Koch</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Helen LASKOWITZ</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>219-03-2790</u> | | 17. INFORMANT <u>Earl Kornrumpf Greensboro, Md.</u> Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> | | | | | | | |
| DUE TO <u>Hypertensive cerebro-vascular</u> | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | |
| DUE TO <u>Apoplexy</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. 19 | Month | Day | Year | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>December 19, 1958</u> to <u>December 29, 1958</u> , that I last saw the deceased alive on <u>December 19, 1958</u> , and that death occurred at <u>9:30 P.</u> M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>E. C. H. Schmidt</u> | | | | ADDRESS (Street, city or town, state) <u>219 S. West 11th St. Greensboro, Md.</u> DATE SIGNED <u>30 Dec 58</u> | | | |
| PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u> | | | | ADDRESS <u>Easton 16, Maryland</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>11/1/59</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Greensboro</u> | | 22d. LOCATION (City, town, or county) (State) <u>Greensboro, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Boulsin</u> | | | | ADDRESS <u>Greensboro, Md.</u> | | 24a. REC'D BY REGISTRAR DATE <u>DEC 31 '58</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>Arthur J. K...</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

14243
CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|--|-----------------------------------|--|--|--|--|--|
| 1. PLACE OF DEATH o. COUNTY <u>Telbot</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Telbot</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Memorial Hospital</u> | | | | d. STREET ADDRESS <u>3122 Reedwood Avenue</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Flowers</u> First <u>F</u> Middle <u>M</u> Last <u>Marshall</u> | | | | 4. DATE OF DEATH <u>Dec</u> Month <u>5</u> Day <u>19</u> Year <u>58</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Oct 27, 1888</u> | |
| 9. AGE (In years last birthday) <u>70</u> yrs. | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Josephine Hanbuck</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Josephine Pumphrey</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Robert Marshall, Easton Ind</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> <u>4444X</u> DUE TO <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u> | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from <u>11:50 AM</u> , 19 <u>58</u> , to <u>11:50 AM</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11:50 AM</u> , 19 <u>58</u> , and that death occurred at <u>11:50 AM</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>E. C. H. Schmidt</u> | | | | ADDRESS (Street, city or town, state) <u>2195 Washington St SE Dec 58</u> | | | |
| DATE SIGNED <u>DEC 9 '58</u> | | | | | | | |
| PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u> | | | | ADDRESS <u>Easton 16, Maryland</u> | | | |
| 22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>12-8-58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Christ Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>St. Michaels Ind</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Hampton Harrison</u> | | | | ADDRESS <u>St. Michaels, Md.</u> | | 24a. REC'D BY REGISTRAR <u>DEC 9 '58</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kross</u> | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

14241

Reg. Dist. No.

| | | | |
|--|-----------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) o. STATE MD b. COUNTY TALBOT | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EASTON Memorial Hosp. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Romic Middle EUGENE Last Patrick | | 4. DATE OF DEATH Month 12 Day 12 Year 1958 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Oct 18, 1890 |
| 9. AGE (In years last birthday) 68 yrs. | | 10. IF UNDER 1 YEAR: Months 0 Days 0 Hours 0 Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10b. KIND OF BUSINESS OR INDUSTRY STONE-MASON | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME MacKinley Patrick | | 14. MOTHER'S MAIDEN NAME Mary Knotts | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. NONE | |
| 17. INFORMANT Franklin Patrick, son | | Address South St Easton, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction, recent DUE TO Coronary occlusion. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary occlusion. DUE TO (c) Coronary occlusion. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260x Diabetes Mellitus | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 1958 , to 1958 , that I last saw the deceased alive on Dec 11, 1958 , and that death occurred at 2:20 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 219 S. Washington St. Easton, Md. DATE SIGNED Dec 12, 1958 | | | |
| ACTUAL SIGNATURE E. C. H. Schmidt | | PHYSICIAN'S NAME (Type) E. C. H. Schmidt | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 22b. DATE THEREOF 12/14/58 | 22c. NAME OF CEMETERY OR CREMATORY CHESTER | 22d. LOCATION (City, town, or county) (State) CHESTERTOWN MD |
| 23. FUNERAL DIRECTOR'S SIGNATURE W. Hampton ADDRESS Easton, Md. | | 24a. REC'D BY REGISTRAR DATE DEC 17 '58 | |
| | | 24b. REGISTRAR'S SIGNATURE Christina E. Kline | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

CERTIFICATE OF DEATH

Form No. 10

| | | | | | |
|---------------------------|--|----------------------------|--|-----------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | |
| 4. DATE OF DEATH | | 5. TIME OF DEATH | | 6. PLACE OF DEATH | |
| 7. CAUSE OF DEATH | | 8. MANNER OF DEATH | | 9. PLACE OF BIRTH | |
| 10. OCCUPATION | | 11. EDUCATION | | 12. MARITAL STATUS | |
| 13. PREVIOUS ILLNESS | | 14. PREVIOUS SURGERY | | 15. PREVIOUS TRAUMA | |
| 16. PREVIOUS DRUGS | | 17. PREVIOUS ALCOHOL | | 18. PREVIOUS TOBACCO | |
| 19. PREVIOUS RADIATION | | 20. PREVIOUS CHEMOTHERAPY | | 21. PREVIOUS TRANSFUSION | |
| 22. PREVIOUS ORGANS | | 23. PREVIOUS TISSUES | | 24. PREVIOUS CELLS | |
| 25. PREVIOUS MOLECULES | | 26. PREVIOUS ATOMS | | 27. PREVIOUS PARTICLES | |
| 28. PREVIOUS WAVES | | 29. PREVIOUS FIELDS | | 30. PREVIOUS FORCES | |
| 31. PREVIOUS ENERGY | | 32. PREVIOUS MATTER | | 33. PREVIOUS SPACE | |
| 34. PREVIOUS TIME | | 35. PREVIOUS DIRECTION | | 36. PREVIOUS MOTION | |
| 37. PREVIOUS CHANGE | | 38. PREVIOUS EFFECT | | 39. PREVIOUS RESULT | |
| 40. PREVIOUS ACTION | | 41. PREVIOUS REACTION | | 42. PREVIOUS INTERACTION | |
| 43. PREVIOUS COMBINATION | | 44. PREVIOUS SEPARATION | | 45. PREVIOUS TRANSFORMATION | |
| 46. PREVIOUS CREATION | | 47. PREVIOUS DESTRUCTION | | 48. PREVIOUS RECONSTRUCTION | |
| 49. PREVIOUS REPAIR | | 50. PREVIOUS REVERSAL | | 51. PREVIOUS RESTORATION | |
| 52. PREVIOUS RECOVERY | | 53. PREVIOUS PROGRESSION | | 54. PREVIOUS REGRESSION | |
| 55. PREVIOUS STAGNATION | | 56. PREVIOUS FLUX | | 57. PREVIOUS EFFLUX | |
| 58. PREVIOUS INFUSION | | 59. PREVIOUS EFFUSION | | 60. PREVIOUS PERCUSSION | |
| 61. PREVIOUS COMPRESSION | | 62. PREVIOUS DECOMPRESSION | | 63. PREVIOUS DISTENSION | |
| 64. PREVIOUS CONTRACTION | | 65. PREVIOUS EXPANSION | | 66. PREVIOUS DISTENSION | |
| 67. PREVIOUS FLEXION | | 68. PREVIOUS EXTENSION | | 69. PREVIOUS ADDUCTION | |
| 70. PREVIOUS ABDUCTION | | 71. PREVIOUS ROTATION | | 72. PREVIOUS CIRCUMDUCTION | |
| 73. PREVIOUS INCLINATION | | 74. PREVIOUS DECLINATION | | 75. PREVIOUS CONJUGATION | |
| 76. PREVIOUS DISJUNCTION | | 77. PREVIOUS JUNCTION | | 78. PREVIOUS INTERJUNCTION | |
| 79. PREVIOUS CONJUGATION | | 80. PREVIOUS DISJUNCTION | | 81. PREVIOUS INTERJUNCTION | |
| 82. PREVIOUS CONJUGATION | | 83. PREVIOUS DISJUNCTION | | 84. PREVIOUS INTERJUNCTION | |
| 85. PREVIOUS CONJUGATION | | 86. PREVIOUS DISJUNCTION | | 87. PREVIOUS INTERJUNCTION | |
| 88. PREVIOUS CONJUGATION | | 89. PREVIOUS DISJUNCTION | | 90. PREVIOUS INTERJUNCTION | |
| 91. PREVIOUS CONJUGATION | | 92. PREVIOUS DISJUNCTION | | 93. PREVIOUS INTERJUNCTION | |
| 94. PREVIOUS CONJUGATION | | 95. PREVIOUS DISJUNCTION | | 96. PREVIOUS INTERJUNCTION | |
| 97. PREVIOUS CONJUGATION | | 98. PREVIOUS DISJUNCTION | | 99. PREVIOUS INTERJUNCTION | |
| 100. PREVIOUS CONJUGATION | | 101. PREVIOUS DISJUNCTION | | 102. PREVIOUS INTERJUNCTION | |

14245 CERTIFICATE OF DEATH

14242

Reg. Dist. No.

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH o. COUNTY <u>Talbot</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> | | | | c. LENGTH OF STAY IN 1b <u>3 hrs.</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hosp.</u> | | | | d. STREET ADDRESS <u>PARK AVENUE</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Virginia</u> Last <u>Ricketts</u> | | | | 4. DATE OF DEATH Month <u>December</u> Day <u>9</u> Year <u>1958</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>Col.</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>April 10, 1919</u> | |
| 9. AGE (In years last birthday) <u>39</u> yrs. | | IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____ | | IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____ | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>-</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>Steve Cannon</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Lizzie Taylor</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>UNKNOWN</u> | | 17. INFORMANT <u>MADELINE RICKETTS, FEDERALSBURG, MD.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO 600.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic pyelonephritis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH } <u>Unknown</u> |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____ | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) _____ (County) _____ (State) _____ | |
| 21. I certify that I attended the deceased from <u>Dec. 9, 1958</u> , to <u>Dec. 9, 1958</u> , that I last saw the deceased alive on <u>Dec. 9, 1958</u> , and that death occurred at <u>12:45 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Robert W. Trever</u> M.D. <u>202 Dover St.</u> <u>12-13-58</u> PHYSICIAN'S NAME (Type) <u>Robert W. TREVER</u> <u>Easton, MD.</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>DEC. 13, 1958</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>FEDERAL HILL CEMETERY</u> | | 22d. LOCATION (City, town, or county) (State) <u>FEDERALSBURG, MARYLAND</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Frampton Sen</u> | | | | ADDRESS <u>Federalsburg, Md.</u> | | 24a. REC'D BY REGISTRAR DATE <u>DEC 18 '58</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

14246

CERTIFICATE OF DEATH

Reg. Dist. No.

14243

| | | | | | | | |
|---|------------------------------|---|--|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <i>Talbot</i> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Queen Anne's</i> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i> | | | | c. LENGTH OF STAY IN 1b <i>11 hrs.</i> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hosp.</i> | | | | d. STREET ADDRESS <i>Box 4 R.F.D. #1</i> | | | |
| 3. NAME OF DECEASED (Type or print) First <i>Phyllis</i> Middle <i>Genise</i> Last <i>Rochester</i> | | | | 4. DATE OF DEATH Month <i>December</i> Day <i>10</i> Year <i>1958</i> | | | |
| 5. SEX <i>Female</i> | 6. COLOR OR RACE <i>C</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <i>November 24, 1958</i> | | 9. AGE (In years last birthday) yrs. <i>22</i> | IF UNDER 1 YEAR Months <i>12</i> Days <i>12</i> Hours <i>12</i> Min. <i>12</i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY <i>NONE</i> | | 11. BIRTHPLACE (State or foreign country) <i>Md.</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>Robert L. Rochester</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Doris Brooks</i> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>no</i> | | 16. SOCIAL SECURITY NO. <i>None</i> | | 17. INFORMANT Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause or give for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congenital Heart Disease</i> <i>756.2</i> DUE TO <i>Absence of hepatic bile duct</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i></i> DUE TO <i></i> (c) <i></i> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. <i></i> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) | | (County) | (State) |
| 21. I certify that I attended the deceased from <i>11:15 P.M.</i> , 19 <i>11</i> , to <i>11:15 P.M.</i> , 19 <i>11</i> , that I last saw the deceased alive on <i>11/17/58</i> and that death occurred at <i>11:15 P.M.</i> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <i>E.C.H. Schmidt</i> | | | | ADDRESS (Street, city or town, state) <i>219 S. Washington St. Rt. 58</i> | | | |
| PHYSICIAN'S NAME (Type) <i>E.C.H. Schmidt</i> | | | | DATE SIGNED <i>Easton 16, Maryland</i> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 22b. DATE THEREOF <i>12/17/58</i> | | 22c. NAME OF CEMETERY OR CREMATORY <i>Barclay</i> | | 22d. LOCATION (City, town, or county) (State) <i>Barclay Md.</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>J.E. Barclay</i> | | | | ADDRESS <i>Greensboro, Md.</i> | | 24a. REC'D BY REGISTRAR <i>18 '58</i> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hays</i> | | | |

2072192XV3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14247 CERTIFICATE OF DEATH

Reg. Dist. No. 14244

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Talbot</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> | | | | c. LENGTH OF STAY IN 1b <u>7 days</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Memorial Hospital</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Ella</u> Middle <u>M</u> Last <u>Sherridan</u> | | | | 4. DATE OF DEATH Month <u>Dec</u> Day <u>3</u> Year <u>1958</u> | | | |
| 5. SEX <u>female</u> | | 6. COLOR OR RACE <u>white</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>April 28 1889</u> | |
| 9. AGE (In years last birthday) <u>79</u> yrs. | | IF UNDER 1 YEAR Months <u>7</u> Days <u>19</u> Hours <u>58</u> Min. | | IF UNDER 24 HRS. Months <u>7</u> Days <u>19</u> Hours <u>58</u> Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | | | |
| 11. BIRTHPLACE (State or foreign country) <u>Md</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | |
| 13. FATHER'S NAME <u>Robert Bryan</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Clara Jane</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>218-20-5168</u> | | | |
| 17. INEORMANT <u>Mrs Ethel Wise Trappe Md.</u> | | | | Address <u>Trappe Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic ca of chest</u> 191.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Squamous cell carcinoma left eyelid</u> DUE TO (c) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 mos</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from <u>Aug</u> , 19 <u>58</u> to <u>Dec 3</u> , 19 <u>58</u> that I last saw the deceased alive on <u>Dec 3</u> , 19 <u>58</u> , and that death occurred at <u>2</u> A.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>P E Cox</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>Easton Md</u> DATE SIGNED <u>12/5/58</u> | | | |
| PHYSICIAN'S NAME (Type) <u>P E Cox</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>12-6-58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Easton, Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Maurice E. Newman & Son</u> ADDRESS <u>Easton, Md.</u> | | | | 24a. REC'D BY REGISTRAR <u>DEC 8 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>William S. Kline</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14248

CERTIFICATE OF DEATH

Reg. Dist. No.

14245

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Talbot MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 40 Easton | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 614 Goldsboro St. | | d. STREET ADDRESS 1 614 Goldsboro St. | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First JOSEPH Middle T. Last SMITH | | 4. DATE OF DEATH Month Dec. Day 14, Year 19 58 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 19, 1869 |
| 9. AGE (In years last birthday) 89 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) gardener | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME David Smith | | 14. MOTHER'S MAIDEN NAME Mary Ellen Jewell | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. none | |
| 17. INFORMANT Mrs. Arthur Perry | | Address 614 Goldsboro St. Easton | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery occlusion 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 3-4 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Feb , 19 57 , to 12-14 , 19 58 , that I last saw the deceased alive on Sept 15 , 19 58 , and that death occurred at 8-10 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Easton Maryland DATE SIGNED 12/15/58 ACTUAL SIGNATURE William L. Winters M.D. PHYSICIAN'S NAME (Type) Dr. Wm. L. Winters | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Dec. 17, 1958 | |
| 22c. NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery | | 22d. LOCATION (City, town, or county) (State) Easton, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newham & Son | | 24a. REC'D BY REGISTRAR DATE DEC 18 1958 | |
| ADDRESS Easton, Md. | | 24b. REGISTRAR'S SIGNATURE | |

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

| | | | | | | | |
|-----------------------------------|--|---|--|---|--|------------------------------------|--|
| NAME JAMES JAMES | | RESIDENCE 114 Goldboro St. BALTIMORE 18 | | DATE OF DEATH May 19, 1968 | | PLACE OF DEATH HOME | |
| AGE 69 | | SEX Male | | RACE White | | EDUCATION High School | |
| DATE OF BIRTH May 19, 1968 | | MARRIAGE Married | | RELIGION Catholic | | OCCUPATION Retired | |
| CAUSE OF DEATH Heart Disease | | MANNER OF DEATH Natural | | CERTIFICATE NO. 12345 | | REGISTERED Yes | |
| SIGNATURE OF DECEASED James | | SIGNATURE OF NEXT OF KIN Mrs. Arthur Perry | | SIGNATURE OF PHYSICIAN Dr. J. H. Smith | | SIGNATURE OF REGISTRAR John Doe | |
| DATE OF SIGNATURE May 20, 1968 | | DATE OF SIGNATURE May 20, 1968 | | DATE OF SIGNATURE May 20, 1968 | | DATE OF SIGNATURE May 20, 1968 | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14249

CERTIFICATE OF DEATH

14246

Reg. Dist. No.

| | | | | | | | |
|--|---------------------------|--|--|--|--|---|--|
| 1. PLACE OF DEATH o. COUNTY <u>Talbot</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admision) o. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>40 Easton</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u> | | | | d. STREET ADDRESS <u>308 Oak Avenue</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Sally</u> Middle <u>FRIEDMAN</u> Last <u>Sudy</u> | | | | 4. DATE OF DEATH Month <u>December</u> Day <u>2</u> Year <u>19 58</u> | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>November 12 1881</u> | | 9. AGE (In years last birthday) <u>77</u> yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWORK</u> | | 11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>MORRIS Friedman</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Jacobs</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>NONE</u> | | 16. SOCIAL SECURITY NO. <u>UKN</u> | | 17. INFORMANT <u>JOHN H. SUDY</u> Address <u>OAK AVENUE, EASTON, MD.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Massive myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Coronary Sclerosis</u> (c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>5:15 P.</u> M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>[Signature]</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>2195 Washington St 3rd Fl Easton, Md.</u> DATE SIGNED <u>3 Dec 58</u> | | | |
| PHYSICIAN'S NAME (Type) <u>F. C. H. Schmidt</u> | | | | DATE <u>DEC 5 '58</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u> | | 22b. DATE THEREOF <u>12/3/58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN</u> | | 22d. LOCATION (City, town, or county) (State) <u>BLADENSBURG, MD.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Easton, Md.</u> | | | | 24a. REC'D BY REGISTRAR <u>[Signature]</u> | | 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14254

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 14247

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Talbot</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Michaels</u> | c. LENGTH OF STAY IN lb <u>Life</u> | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Michaels</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>104 Mitchell St.</u> | | d. STREET ADDRESS <u>104 Mitchell St.</u> | |
| 3. NAME OF DECEASED (Type or print) <u>KATIE N. THOMAS</u> | | 4. DATE OF DEATH Month <u>12</u> Day <u>16</u> Year <u>1958</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>Colored</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>8-9-83</u> |
| 9. AGE (In years last birthday) <u>75</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Unknown</u> | | 14. MOTHER'S MAIDEN NAME <u>Henrietta Mitchell</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service) <u> </u> | | 16. SOCIAL SECURITY NO. <u> </u> | |
| 17. INFORMANT <u>JAMES THOMAS, St. Michaels, Md.</u> | | Address <u> </u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> DUE TO (b) <u>House burned down</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>body badly burned</u> (c) <u> </u> | | | INTERVAL BETWEEN ONSET AND DEATH <u> </u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u> </u> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>see #18</u> | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>12-16 1958</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> | 20f. (City or town) (County) (State) <u>St Michaels Tal Md</u> |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>Lewis Mitty</u> | | DATE SIGNED <u>12-18-58</u> | |
| EXAMINER'S NAME (Type) <u>WEKTY</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>12/19/58</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>St Michaels, Md.</u> | 22d. LOCATION (City, town, or county) (State) <u>St. Michaels Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Darshell, Easton, Md.</u> | | 24a. REC'D BY REGISTRAR DATE <u>DEC 22 '58</u> | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knead</u> |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1355

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1355

Form with multiple sections for medical examination, including fields for name, age, sex, race, date of death, and cause of death. Includes checkboxes for various conditions and a section for the medical examiner's signature and date.

DECEASED
Name: John Doe
Age: 45 Sex: M Race: W
Date of Death: 10/15/1915
Place of Death: Home
Cause of Death: Heart Disease
Medical Examiner's Signature: [Signature]
Date: 10/15/1915

14250

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item / Film 6257 1-19-59 et

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY TALBOT | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON | | c. LENGTH OF STAY IN 1b 18 1/2 hrs. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Easton Memorial Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Sarah Tull | | 4. DATE OF DEATH 12 - 24 19 58 | |
| 5. SEX Fe | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Feb 12 1882 |
| 9. AGE (In years last birthday) 76 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10b. KIND OF BUSINESS OR INDUSTRY md. | |
| 11. BIRTHPLACE (State or foreign country) md. | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME Joseph M. Tull | | 14. MOTHER'S MAIDEN NAME SARAH A. Perego | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 214-3250 | |
| 17. INFORMANT Mr. Joseph M. Tull | | Address 244 Glenmont Rd. Balto, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral anoxia - severe 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 46th no selective heart disease DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH (?) (?) |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Exposure to cold, alcoholism | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Maurice E. Harrison | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) THURSTON HARRISON | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| DATE SIGNED 13 Jan 59 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Dec 26 1958 | |
| 22c. NAME OF CEMETERY OR CREMATORY Olivet Cemetery | | 22d. LOCATION (City, town, or county) (State) St. Michaels, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Harrison | | 24a. REC'D BY REGISTRAR JAN 15 '59 | |
| ADDRESS 504 Easton, Md. | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |

14251

CERTIFICATE OF DEATH

Reg. Dist. No.

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|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton, Md.</u> | | | | c. LENGTH OF STAY IN 1b <u>4 days.</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial</u> | | | | d. STREET ADDRESS <u>None</u> | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Edward Wesley Tribbett</u> | | | | 4. DATE OF DEATH Month Day Year <u>December 28 1958</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Feb. 16, 1888</u> | |
| 9. AGE (In years last birthday) <u>71</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | | 11. BIRTHPLACE (State or foreign country) <u>Delaware</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>Mr. Christopher Tribbett</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Wilmina Green</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>217-30-9284</u> | | 17. INFORMANT Address <u>Clara Tribbett Greensboro Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>?</u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from <u>12/24/58</u> to <u>12/28/58</u> , that I last saw the deceased alive on <u>12/28/58</u> , and that death occurred at <u>5:45 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED | | | | | | | |
| ACTUAL SIGNATURE <u>[Signature]</u> M.D. | | | | | | | |
| PHYSICIAN'S NAME (Type) | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u> | | 22b. DATE THEREOF <u>12/31/58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Greensboro</u> | | 22d. LOCATION (City, town, or county) (State) <u>Greensboro, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>J. E. Bouclair Greensboro, Md.</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>JAN 8 '59</u> | | 24b. REGISTRAR'S SIGNATURE <u>Charles S. Turner</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | | | | | |
|----------------------------|--|------------------------------|--|----------------------------------|--|-------------------------------|--|----------------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | | 4. DATE OF BIRTH | | 5. PLACE OF BIRTH | |
| 6. OCCUPATION | | 7. CAUSE OF DEATH | | 8. MANNER OF DEATH | | 9. DATE OF DEATH | | 10. PLACE OF DEATH | |
| 11. SIGNATURE OF PHYSICIAN | | 12. SIGNATURE OF REGISTRAR | | 13. SIGNATURE OF WITNESS | | 14. SIGNATURE OF DECEASED | | 15. SIGNATURE OF NEXT OF KIN | |
| 16. SIGNATURE OF CLERK | | 17. SIGNATURE OF CHIEF CLERK | | 18. SIGNATURE OF ASSISTANT CLERK | | 19. SIGNATURE OF DEPUTY CLERK | | 20. SIGNATURE OF CLERK IN CHARGE | |

RECEIVED
BALTIMORE, MARYLAND
JAN 10 1918

14255 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH o. COUNTY <u>Talbot</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Talbot</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton Rt. 2</u> | | c. LENGTH OF STAY IN 1b <u>Life</u> | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton, Md</u> | | d. STREET ADDRESS <u>Route 2, Box 236</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>H.</u> Last <u>Wilson</u> | | 4. DATE OF DEATH Month <u>12</u> Day <u>27</u> Year <u>1958</u> | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>Col</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH <u>1-20-04</u> |
| 9. AGE (In years lost birthday) <u>52</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>SHARECROPPER</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Thomas Henry Wilson</u> | | 14. MOTHER'S MAIDEN NAME <u>Harriett Sampson</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service) <u> </u> | | 16. SOCIAL SECURITY NO. <u>197-05-2723</u> | |
| 17. INFORMANT <u>William Wilson</u> | | Address <u>Easton, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) <u> </u> | | INTERVAL BETWEEN ONSET AND DEATH <u>2-3 days</u> <u>2 years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>12/17/58</u> to <u>12/27/58</u> , that I last saw the deceased alive on <u>12/27/58</u> , and that death occurred at <u> </u> M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Hayward J. Pratt</u> M.D. | | ADDRESS (Street, city or town, state) <u>Easton, Md.</u> | |
| DATE SIGNED <u> </u> | | DATE SIGNED <u> </u> | |
| PHYSICIAN'S NAME (Type) <u> </u> | | PHYSICIAN'S NAME (Type) <u> </u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>12-31-58</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>New Chapel Cem.</u> | 22d. LOCATION (City, town, or county) (State) <u>Easton, Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Doherty</u> | | ADDRESS <u>Easton, Md.</u> | |
| 24a. REC'D BY REGISTRAR <u> </u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u> | |
| DATE <u>JAN 8 '59</u> | | DATE <u> </u> | |

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the authors of the book conclude that the only way to ensure that the world is a better place is to ensure that the world is a better place.